Reviewer's report

Title: How do junior doctors in the UK learn to provide end of life care: A qualitative evaluation of education

Version: 1 Date: 12 June 2015

Reviewer: Caroline Barry

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Discretionary Revisions

1. The research question could be more clearly defined in order to distinguish this study from much of the literature in this area by stating clearly in the title that the study is a qualitative evaluation of postgraduate education.

2. Line 72 refers to understanding how doctors gain the “required competencies” to improve education and patient care. For clarity, it may be helpful to state what the “required competencies” in end of life care for a junior doctor.

3. The study may benefit from more information regarding the characteristics of the participants. There is a large range in postgraduate experience given that Core Medical Training is only two years long and most go straight into it from Foundation Training – what was the mean length of postgraduate experience? Given that the paper concludes junior doctor's confidence in end of life care increases as their career progresses (line 386) was it demonstrated that those with more postgraduate experience felt more confident than those with 3 years' less experience?

4. More specific information could be provided regarding the data collection; were the interviews recorded by video or audio? What was the setting?

5. I note that ethical approval was sought for the study. A number of participants identified the emotional impact that EOLC had on them. (line 191 “it was an experience that has kind of stuck with me”) Given that this may have been the first opportunity they had been given to reflect on these clinical situations, how did the researcher handle the effects of the study on the participant both during and after the study? Given the sensitive nature of the discussion more detail could be provided as to how ethical standards were maintained throughout the study.

6. Line 313 “there was an impression that once a decision has been made to take a palliative approach all further decisions were often left to this team”. Was this ‘impression’ formed from the views of one participant or more than one? Did this alter as clinical confidence improved? Did this alter by speciality? Could a quote be used to support this statement?

7. The study concludes by stating that confidence in end of life care increases as careers progress due to clinical experiences. Given that the main training needs
identified were recognition of the dying patient and lack of clarity around treatment plans. I am not sure at present that sufficient evidence is presented to support the conclusion that an increase in formal teaching would ‘embed principles of good quality care in practice’.

8. Line 342 “guidance on prescribing was particularly emphasised” emphasised in what way – positive, negative or lacking?

9. Acknowledgement of the limitations of the study in terms of applicability across the country – It is stated that there is no formal teaching for CMTs in Wessex (line 170). This may not be the case across other deaneries which may limit the wider applicability of the study.

10. Line 323 “this was sometimes limited by workload and working patterns”. I’m not sure that this statement has been justified by any other discussion in the analysis.

11. Line 336 – study finding probably not sufficient to “amplify” national concerns but they might reflect them.

Minor Essential Revision
1. Line 494: typo “Department of Hleath”
2. Line 67 – removed hypen in “high-lighted”

Major Compulsory Revisions
1. There needs to be more critical examination of the researcher role and the potential for bias in data collection and interpretation of results. I note that the lead author is based in Dorset, which is within the Wessex deanery. Did, or had she, worked in the same hospital as any of the trainees? Was she known to any of the participants and were they known to her? Does she have an educational role in addition to a clinical role within this area that might influence either the responses of the participants or the formulation of research questions? If this was considered, what role was taken to minimise potential bias when identified? May the overwhelmingly positive opinion of the specialist palliative care team expressed during the interview have any relevance to the speciality in which the researcher is working?

2. A negative view is presented of the “general ethos” (line 235) surgical profession, but this account is provided by doctors who have chosen not to pursue a career in surgery. Surgeons were also referred to as “what not to do” (line 334) in clinical consultations. The participants’ experiences may have guided career choice and may not be representative of the surgical specialty as a whole and this should be acknowledged. Many who have had positive experiences in surgical training may be more likely to pursue higher training in this area but were not sampled in this study.

**Level of interest:** An article whose findings are important to those with closely related research interests
Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests